STATE OF NORTH DAKOTA

MARKET CONDUCT EXAMINATION REPORT

LINCOLN MUTUAL LIFE AND CASUALTY
INSURANCE COMPANY
203 NORTH 10TH STREET
FARGO, ND 58102

As of December 31, 1999

By Representatives of the
North Dakota Insurance Department

STATE OF NORTH DAKOTA

DEPARTMENT OF INSURANCE

I, the undersigned, Commissioner of Insurance of the State of North Dakota do hereby certify that I have compared the annexed copy of the Market Conduct Examination Report of the

Lincoln Mutual Life and Casualty Insurance Company
203 North 10th Street
Fargo, ND 58102

as of December 31, 1999, with the original on file in this Department and that the same is a correct transcript therefrom and of the whole of said original.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal at my office in the City of Bismarck, this 17th day of August, 2001.

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Jim Poolman
Commissioner of Insurance

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Fargo, North Dakota
July 27, 2001

Honorable Jim Poolman
Commissioner
North Dakota Insurance Department
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Commissioner Poolman:

Pursuant to your instructions and in accordance with N.D. Cent. Code § 26.1-03-19.2 and the rules, regulations, and procedures established by the National Association of Insurance Commissioners (hereinafter referred to as the "NAIC"), a comprehensive market conduct examination has been made of the North Dakota business of:

Lincoln Mutual Life and Casualty Insurance Company
Fargo, North Dakota

at its home office located at 203 North 10th Street, Fargo, North Dakota. A report thereon is submitted as follows:

INTRODUCTION

This examination was conducted by the North Dakota Insurance Department Market Conduct Examiner at the Company's home office.

SCOPE OF EXAMINATION

This examination began on November 29, 1999, and the on-site portion was concluded on January 7, 2000. It was conducted concurrently with a statutory financial examination and generally covered the time period from July 1, 1994 through December 31, 1999, together with consideration of prior or subsequent matters as deemed pertinent in the judgment of the examiner. The examination was conducted in accordance with N.D. Cent. Code §§ 26.1-03-19.2, 26.1-03-19.3, and 26.1-03-19.4, and under rules and regulations prescribed by the National Association of Insurance Commissioners (NAIC) to verify the Company's compliance with statutes and regulations relating to market conduct practices and to determine if operations were consistent with the public interest.

The major areas reviewed were:

1. Company operations/management.
2. Complaint handling.
3. Marketing and sales.

4. Producer licensing.

5. Policyholder service.

6. Underwriting.

7. Claims practices.

This is a report by text. Attention is directed to the comments, suggestions, and recommendations in the “Summary of Recommendations” section of the report.

COMPANY PROFILE

The Company was incorporated in 1935 and registered with the State of North Dakota on October 3, 1935, as Lincoln Mutual Life and Casualty Insurance Company (hereafter referred to as “LML” or “the Company”). During the pertinent times of the examination, it was and remains licensed to sell life insurance, annuities, accident and health insurance, disability insurance, and credit life and health insurance. In North Dakota, LML currently sells only life insurance, accident and dismemberment insurance, long- and short-term disability policies, and maintains annuities sold from previous years. It has not sold annuities for approximately a decade. It is licensed in the states listed below and sells health insurance in South Dakota only.

Lincoln Mutual has entered into numerous agreements with various insurers and reinsurers that will only briefly be detailed in this report and more fully examined in the financial report.

In 1989 LML entered into a Facilities Management and Services Contract with Coordinated Insurance Services, Inc. (CISI, now known as Noridian Insurance Services, Inc.) NISI is 99% owned by Noridian Mutual Insurance Company, doing business as Blue Cross Blue Shield of North Dakota. The joint operating agreement states that NISI provides long-term administrative, management, marketing, and insurance services for LML. All LML employees became Noridian employees as a result, and LML is considered an affiliate of Noridian. (For purposes of this report, the Lincoln/Noridian employees will be referred to as Lincoln employees to differentiate them from the Noridian/Blue Cross employees.) Noridian is responsible for future contributions to employee retirement plans that will be detailed in the financial report. Lincoln Mutual is Noridian’s group life, long-term disability, and short-term disability carrier. These products are marketed through Noridian service centers, through NISI agents, and with Noridian/Blue Cross health insurance, dental and vision coverage.

Lincoln also has been affiliated with Pioneer Mutual Life Insurance Company, and the companies share the same building and have at times shared staffing and resources. Pioneer Mutual administered Lincoln’s life and short-term disability claims from 1991 until January 1, 1999. At that time a decision was made by Lincoln to bring its claims administration in-house. Two 1992 agreements resulted in Lincoln becoming the reinsurer for Pioneer for a closed block of business that included individual life insurance policies sold by Pioneer. By virtue of those agreements, Lincoln became the group life insurance outlet, selling group life on Pioneer paper and reinsuring these policies 90%. A more detailed analysis of these arrangements is contained in the financial examination report.

Lincoln has approximately 1,500+ life groups, many with disability insurance. The larger groups

are composite rated. The smaller groups age rated. They are all term life policies with guaranteed rates for the first two years and annually renewable.

The Company also assumed a block of business from Medical Life Insurance Company. Based on the Company's statements, the relationship is characterized as follows:

> In 1995 Lincoln assumed a block of 1,200 life and disability groups from Medical Life Insurance Company of Cleveland, Ohio. Northern Plains Life Insurance Company sold much of the business, owned by Noridian until 1990. At that time Noridian sold Northern Plains Life to Medical Life. The 1995 agreement specified that Lincoln assume 100% of the business and reinsured 80% back to Medical Life. Lincoln then retained an additional 20% per year until 1999, when the Company then retained 100% of the risk. This block is now reinsured by Swiss Re Life and Health America, Inc. Lincoln's retention is up to $40,000 per person.

The long-term disability (LTD) policies are 100% reinsured by Duncanson & Holt Services, Inc., as an intermediary for American Disability Reinsurance Underwriter's Syndicate (ADRUS), and Lincoln Mutual only keeps administration fees. Duncanson & Holt (D&H) performs some of the claims administration of the LTD policies. This contract, which essentially amounts to a third-party administration (TPA) agreement, was first executed with D&H in 1989. The short-term disability (STD) products are 100% insured by Lincoln Mutual. A new STD product approved by the Department in late 1999 will be a 50/50 reinsurance split with D&H. At the date of this exam, no policies had been sold. It is part of a package of "seamless" coverage marketed with long-term disability coverage.

Lincoln's accidental death and dismemberment (AD&D) policies, as of January 1, 1998, are 90% reinsured by Swiss Re up to $100,000. Lincoln Mutual pays the remaining 10% of the death benefit. Before 1998, the AD&D policies followed the same retention limits and reinsurance as the life policies. The AD&D portion of some older voluntary group term life policies are reinsured 100% by USAble.

Lincoln sells health insurance policies in South Dakota and benefits under those policies are administered through Benefit Plan Administrators, a Fargo, North Dakota, third-party administrator that is also a subsidiary of Noridian.

As of December 31, 1998 (the last year for which an Annual Report was available), the Company reported on its Schedule T form as being licensed in the following states:

Arizona	Colorado	Idaho	Kansas
Minnesota	Montana	Nebraska	North Dakota
Oklahoma	Oregon	South Dakota	Utah
Wisconsin	Wyoming		

Its premium volume for 1998, the last year for which statistics were available, was $4,334,897 for life insurance, $51,429 for annuities, and $12,236,687 for accident and health insurance.

AREAS OF REVIEW

Company Operations/Management

Licensing and Contractual Issues

The Company agreements with Noridian, D&H, and other reinsurers have resulted in LML sharing some decision-making with outside companies. It handles its own short-term disability claims and assists the outside companies with long-term disability and life claims.

D&H, since the August 1, 1989, agreement with LML, has essentially operated as a third-party administrator (TPA) for Lincoln administering the long-term disability claims. As such, under N.D. Cent. Code Chapter 26.1-27, it must be licensed as a TPA. Specifically, N.D. Cent. Code § 26.1-27-03 mandates licensure and penalties for noncompliance. According to Departmental records, D&H did not become licensed as a TPA in North Dakota until November 15, 1996.

A D&H subsidiary, Claims Service International, Inc. (CSI), also fits the statutory definition of a TPA because it has responsibility for claims settlement of the long-term disability policies. A random check of claims indicates that CSI has been settling claims as far back as May 9, 1996 (Claim No. 229-96-0016). Departmental records indicate that it was not licensed as a TPA in North Dakota until March 5, 1999.

A more problematic agreement is a "Continuation of Coverage" contract with Blue Cross of Montana (BCM). The first agreement between the two entities was signed in December 1997 for one year. LML agreed to assume liability for future BCM claims in the event that BCM would be declared insolvent. The agreement, which amounts to a surety bond, was renewed in December 1998 for 1999 and again in December 1999 for 2000, even though Department examiners raised concerns about the risk. In each year of the agreement, BCM paid LML $20,000. Lincoln's Certificate of Authority does not permit it to act as a surety under N.D. Cent. Code §§ 26.1-02-02, 26.1-02-05, and 26.1-02-06(2).

Because the Department raised concerns about the sufficiency of Lincoln's reserves and the potential for catastrophic consequences in the event of a BCM insolvency, the Company has agreed not to renew the coverage agreement after the year 2000.

Recommendation No. 1: Lincoln Mutual should ensure compliance with all licensing and statutory requirements by any entity with which it contracts.

Administration of the Group Policies

N.D. Cent. Code § 26.1-03-19.3 outlines the scope of market conduct examinations and recommends that examiners follow guidelines set up by the National Association of Insurance Commissioners (NAIC). The NAIC Market Conduct Examiner's Handbook, Volume II, recommends that examiners "focus on general business patterns and practices." For these reasons, the examination concentrated on the way the group policies were being sold, administered, and maintained.

N.D. Cent. Code § 26.1-33-02 states that:

> Insurers shall deliver to purchasers of life insurance information which will improve the purchaser's ability to select the most appropriate plan of life insurance for the purchaser's needs, which will improve the purchaser's understanding of the basic features of the policy which has been purchased or which is under consideration, and which will improve the ability of the purchaser to evaluate the relative costs of similar plans of life insurance. The commissioner may adopt reasonable rules to implement this section.

The Company communicates with its groups by sending out an administration packet to the employer, responding to service calls, and occasionally sending out requests for updates on the names of group leaders or human resource directors. The Company sends out forms to employers to confirm that the certificate holders have been provided their schedules of benefits, although not all of the files pulled during the exam contained the employers' signed confirmations.

The Administration Manual asserts, "The success of a group insurance plan is contingent on the efficiency of its administration." The manual offers employers the choice of "Home Office Administration" or "Self-Administration'. The examiner could not tell which plans were which during the exam. The Administration Manual also states, "This kit is your key to trouble-free administration." These marketing materials paint an overly-optimistic vision of how the plans work once the contracts are signed.

Once a contract is signed for group coverage, the individual applications are filled out by employees. Although group leaders are provided with administration materials, it is unclear how much additional training is provided by the Company. Inadequate training appears to be causing excessive errors in plan administration. The Department believes this could be remedied through annual training sessions, newsletters, and more frequent formal communications with the groups.

Mistakes were discovered on the applications in the files and it became apparent to the examiner that enrollees were having problems filling out the applications, evidencing insufficient oversight by either the agents, group leaders, or the insurers to assist them and to minimize the errors. The mistakes included employees signing up for the wrong type of coverage, neglecting to sign up for dependent coverage, returning incomplete or unsigned applications, omitting beneficiaries for life coverage, omitting salary information for disability coverage, and general misunderstandings of what they were applying for or what type of coverage they were even eligible for. In some files, many submitted applications were incomplete or incorrect. The frequency of these mistakes indicates that policyholders or prospective insureds are not being given adequate information in the solicitation and purchase phase of the product.

The Department recommends that the Company improve training of service centers, agents, and employers to better administer the group insurance plans and minimize the inefficiencies and the costs of those inefficiencies. It should embark on a training program especially targeted to the groups who have demonstrated trouble administering the various plans. The training should include assistance in filling out all forms used, information on the claims process, updates on the laws, and other pertinent matters. The Company needs to increase its communications with each group, and especially with those groups with frequent employee turnover that have shown an inability to understand or administer the plans. This should minimize misunderstandings

about the nature of coverage and the eligibility requirements, and prevent complaints from enrollees who do not understand the type of coverage they are purchasing.

The companies send out a monthly combined bill that is prepared separately by each insurer and sent out through Noridian. It lists each type of coverage the group is obtaining and a break-down of premiums for each separate line. The Company indicated that this combined billing has been extremely popular with the employer groups because they can issue one payment for all coverage each month.

Included with the monthly billings is a "premium billing change worksheet" or "change report" sent to each group to add new employees, delete terminated employees from coverage, or change types of coverage for individuals adding or dropping certain insurance. The examination showed employers had difficulty completing change reports and errors and gaps in coverage resulted for enrollees. In many cases, an employee would request deletion from one type of coverage, but then lose all other forms of coverage when either Noridian or LML deleted the individual from the system entirely. It was months before an employer spotted the discrepancy and requested reinstatement. Often, the employers were not using the report sheets and were submitting handwritten notes, memos, e-mails, or telephone calls of changes. Examples of these practices are attached as Appendix "A".

Random samples of group files that are listed in Appendix "A" show both disability and life files contain mistakes including the following: enrollees mistakenly dropped from coverage due to clerical or administrative mistakes and requiring reinstatement, mistakes when the type of coverage applied for was not what was being billed or provided, omission or deletion of dependents, or sales to ineligible persons that necessitated subsequent rescission of the contract. Additionally, examples of the following were found in the files: incorrect types of coverage, incorrect contract numbers, incorrect effective dates of coverage, incorrect premium amounts and benefit levels, and missing applications. These were further indicators that the insured groups or individuals did not understand what they were buying, which suggests potential noncompliance with N.D. Cent. Code § 26.1-33-02, and unnecessarily high administrative costs incurred in reconciling errors.

The examiner found examples such as the following: One individual was not insured for five months (2024130). Another was "back-billed" for four months of coverage that apparently was not provided (2052517 or 2226500). These "back-billings" for missed or reinstated individuals were found in nearly all of the life group files pulled. The examiner also found employer concerns about incorrect billing addresses (6627701); non-receipt of monthly statements (665001); misunderstandings about eligibility criteria for certain types of coverage that led to ineligible individuals being insured (FMI group); calls from groups wanting to ensure that submitted changes were in fact being processed (City of Minot group); memos from employers to ensure proper reinstatement of improperly terminated coverage or coverage that was never instituted but requested, billed, and paid for (2030626).

The Prohibited Practices Act, N.D. Cent. Code § 26.1-04-03(1), becomes relevant. The Company must be careful not to misrepresent the quality of service contained in the insurance contracts it sells in an effort to entice buyers. Most of the sales materials for the contracts, to be specifically discussed below, made service promises that should be fulfilled in the ongoing administration of the products.

In some cases, the systemic problems were minimized by the selling agents – "benefits specialists" B who assisted the groups in the ongoing administration of the plans. The Grand Forks service center deserves mention for exceptional handling of plans after the sale. The

service centers in the north and western areas of the state appeared to have poorer assistance. It appeared that after the sale, agents in those regions did not make themselves readily available for services. The remainder of the service centers randomly checked during other portions of the exam fell somewhere in between but appeared to have diminished visibility after sales.

When the Company sends out administrative kits that proclaim they are the key to trouble-free administration, the expectations by the buyer are that the Company will smoothly administer the plans. Based on the administrative problems encountered after the sale, it is the opinion of the Department that the Company has not fulfilled this promise. The exhibits in Appendix "A" appear to illustrate some administrative shortcomings, in contrast to the service promises.

The Company must be careful not to promise administrative services it is not performing, or performing inadequately, to be in full compliance with the advertising rules and N.D. Cent. Code § 26.1-04-03.

Recommendation No. 2: The Company needs to bring its practices in soliciting life insurance and administering the policies into compliance with N.D. Cent. Code § 26.1-33-02.

If a group sponsors a Noridian health plan, the combined application is used and the individual applications go to Noridian where the data is keyed into the computer system. Lincoln employees told the examiner that because of copying costs, Noridian does not send LML photocopies of the individual applications for LML's files. Even though the data is available in the computer, LML must rely on Noridian to correctly input the information and manage it from inception. Random checks of the hard copy files at Lincoln found dozens of incidents where individual and group applications could not be located. Applications were not attached to the various policies as required by N.D. Cent. Code §§ 26.1-33-01, 26.1-33-05(4), and 26.1-33-11(3) and it was not clear from the files if the policyholders were being provided entire copies of the contracts along with their applications. Since the application forms are a part of the overall contract, this oversight should be corrected. The company needs to employ due diligence to ensure that its business practices comply with all applicable statutes.

Recommendation No. 3: A completed application should be attached to the various policies in accordance with N.D. Cent. Code §§ 26.1-33-05(4) and 26.1-33-11(3), as it forms an integral part of the contract. Under N.D. Cent. Code § 26.1-33-01 the complete form should be provided to both policyholder or and certificate holder and a copy of both the application and the contract should be retained by the company.

The exam found other problems in administering the group coverage. Eligibility was a primary concern that will be discussed more fully in the "Claims Handling" section of this report. Group leaders appeared to be misapplying initial eligibility criteria, whether it was keyed to the minimum number of hours worked, salary requirements, or other factors. Again, better training to explain the plans is necessary to comply with N.D. Cent. Code §§ 26.1-04-03 and 26.1-33-02 and N.D. Admin. Code §§ 45-04-01-01(3) and 45-06-04-04.

The more problematic issue with respect to continuing eligibility is that a sympathetic employer can elect to keep a disabled or retired employee on the payroll without the Company's knowledge, thus evading the eligibility criteria. In this respect, the groups can wield considerable power in attempting to circumvent the eligibility requirements. Better monitoring of the groups

could eliminate potentially unfavorable claims outcomes and attempts to circumvent underwriting guidelines that increase the company's risk.

The exam also noted one incident in which the group representative, when informed by the Company that the employer needed to provide waiver cards to employees in order to fulfill the required 100% enrollment, simply filled out the cards herself and signed the employees' names as affirmatively refusing coverage. She then placed her own initials beside the signatures. No explanation was in the file indicating that she had permission to sign for the employees refusing coverage or that the employees were even informed that coverage was available. If the employer intended to deceive the insurer or its own employees, such practices are prohibited in N.D. Cent. Code §§ 26.1-02-24.1 and 26.1-02.1-02. The examiner found these easily so a quick review by the company should have detected them.

Recommendation No. 4: The Company must exercise due diligence to ensure compliance with N.D. Cent. Code §§ 26.1-02-24.1 and 26.1-02.1-02.

It should be noted that when an employer group simply elects life or life and disability coverage, Lincoln Mutual administered the plans and performs the initial data input into its own computer system. Noridian had no involvement in either the computerization or billing of these plans. The rate of mistakes found dropped significantly. There were almost no incidents found of dropped coverage, reinstatements, mistakes filling out monthly forms, and "back-billing" when Lincoln Mutual administered its own plans.

Among the communications requested by the examiner, the Company provided a 1998 Annual Report which states that in 1999, the company commissioned a customer satisfaction survey that was performed by a Fargo marketing firm. It generally gave the Company high marks for service but noted a decrease in personal contacts with Lincoln Mutual that could be attributed to insureds contacting Noridian for problems. This may be another indicator that consumers are misinformed into believing that the Lincoln products they purchased are Noridian's.

Finally, the Company has taken preliminary steps to formulate a fraud committee, but it needs to continue its efforts and meet more regularly. Since February 1997, a joint committee of Noridian, Pioneer Mutual, and Lincoln Mutual employees has met only three times to discuss fraud-related insurance issues. It should be noted that the 1997 certificate for long-term disability does contain provisions for handling fraud.

Complaint Handling

The Company has no complaint register or written grievance procedures as suggested by the NAIC and applicable statutes. The lack of any formal procedures constitutes a prohibited practice in North Dakota. Specifically, N.D. Cent. Code § 26.1-04-03(10) requires that a company adopt reasonable standards for the prompt handling of complaints or grievances. N.D. Cent. Code § 26.1-36-42 provides that accident and health insurers must adopt grievance procedures. The Company provided a half-page memo of procedures dated from June 26, 1997, that were not being followed because the Company was not compiling or recording complaints.

Recommendation No. 5: The Company should adopt and follow formal procedures for complaint handling, including the use of a complaint register, and maintain thorough records on a calendar year basis as set forth in N.D. Cent. Code § 26.1-04-03(10). Additionally, the Company should develop formal grievance procedures as set forth in N.D. Cent. Code § 26.1-36-42 and include these procedures in all life and disability contracts.

The examiner was provided with two complaints from 1999 and one dated in 1995. One of the 1999 complaints was from a South Dakota resident and was directed to that state. The South Dakota Division of Insurance resolved it. The Company's response was prompt. The other 1999 complaint was resolved during the course of this exam. Again, the Company's response was prompt. The 1995 complaint was promptly forwarded by Lincoln to Medical Life Insurance Company for resolution.

The 1999 North Dakota complaint concerned dependent life coverage. The complainant paid dependent life coverage well after her children had lost their eligibility and wanted to know why someone did not inform her to take the children off the plan. The Company indicated that it does not keep records of dependents' birth dates and only determines eligibility upon presentation of a claim.

The Department would recommend the Company do a better job of explaining conversion options as provided in N.D. Cent. Code § 26.1-33-11(9). The Department recommends the Company track birth dates of dependents and spouses in its computers and periodically remind employers about retirement options and expiration of existing coverage. N.D. Cent. Code § 26.1-33-12 gives individuals additional time to convert group life policies if the individual is not given written notice of existence of conversion rights. While Form LMGC-201-LH 10-94 and Form NPGC-101-LH did correctly explain conversion options for both primary insureds and dependents, many certificates randomly checked only indicated that coverage terminated at retirement, but did not give conversion options.

The majority of the complaints on contested claims involved non-entitlement to death benefits due to common misperception that the term life policies continued after retirement. This is an indication of poor communication and possible noncompliance with N.D. Cent. Code § 26.1-33-02.

Recommendation No. 6: The Company should ensure compliance with N.D. Cent. Code §§ 26.1-33-11(9) and 26.1-33-12 and provide written notice or require proof of written notice to all terminated, retired, or otherwise ineligible employees and dependents of their rights to convert any group policies to individual coverage. If conversion options do not exist on certificates, individuals should receive written notification under the statutes.

Finally, none of the contracts, certificates, or benefits schedules reviewed for this exam list procedures for defining grievances or filing complaints, explaining dispute resolution, or even noting where insured persons can complain. The Prohibited Practices Act, N.D. Cent. Code § 26.1-04-03(10) mandates that companies adopt and implement reasonable standards for the handling of written communications to the company. Under this statute, the Company needs to do a more thorough job of tracking and responding to complaints and identify problem areas to

both its employer groups and their employees to ensure full compliance with the law. Responses to individuals should not be directed to the group. They should be addressed to the individual and, if necessary, copied to the group representative if they do not compromise privacy issues.

Marketing and Sales

The Company, since the 1989 agreement with Noridian, has marketed its products to groups through regional Blue Cross service centers throughout North Dakota. These service centers have packets of information on the various lines of insurance the agents sell. The LML kit includes marketing brochures, agent or field marketing guides, benefits brochures, service requests, group applications and individual enrollment forms, claim forms, and change forms. The materials are available for life, accident and disability lines of insurance, and for small and large groups. Underwriting manuals were available for the newer disability products, but not for some of the older lines, and underwriting manuals were not included in the older life insurance packets.

The Company's advertising and promotional literature was reviewed for conformance with state regulations and statutes. The Company does not appear to keep a formal advertising file and should, in accordance with N.D. Admin. Code § 45-06-04-11.

At least one brochure for long-term disability policies did not define what an "elimination period" was and this could be confusing to certificate holders. Form LML-97-LTD, one of the newer long-term disability plans, did contain the essential definitions.

In one brochure for large group long-term disability insurance, the definition of "total disability" did not match the corresponding Field Marketing Guide. One long-term disability Procedures Manual was outdated and appeared to contain statistics that needed updating in its "Trends" section.

Recommendation No. 7: The brochures and promotional materials delivered to potential policyholders should contain definitions of all key terms so that prospective insureds can make informed decisions about whether to purchase coverage and to fully advise them of the benefits they are purchasing. Those definitions should match the definitions in the materials employers will use to explain or administer the plans.

One contract's "Glossary of Terms" contained an outmoded description of what a pre-existing condition is. The following language has been specifically deleted from current statutes: "where symptoms were present" or language such as "symptoms manifested." Because this language is not contained in N.D. Cent. Code § 26.1-36-05(5), it should not be used, and all contracts in existence with outdated language should be brought into compliance.

Recommendation No. 8: The Company should review all contracts, brochures, and manuals in force and bring descriptions of key terms into compliance with existing North Dakota laws.

The examiner also noted discrepancies on the various publications as to when dependent coverage began. One application said "14 days," while a manual indicated "15 days." These

eligibility dates should be reconciled to make sure that the information indicated on the applications is identical to the various contracts, manuals, and schedules of benefits.

No other discrepancies were noted in the advertising materials.

Agent Licensing

A review of the Company's agent lists and licensing was conducted. During the random sampling of the files pulled in Appendix "C", at least one agent was discovered to have sold policies before being validly licensed in life insurance. Agent Hatfield sold life insurance policies in 1995 and 1996. Departmental records indicate she did not receive a life insurance license or appointment by Lincoln for life insurance until January 31, 1997. Sales of insurance products before licensure and appointment by a company are in violation of N.D. Cent. Code §§ 26.1-26-03 and 26.1-26-13.

No other discrepancies were noted.

Recommendation No. 9: Lincoln should review all of its agent files to ensure that agents are properly licensed and appointed to sell the various lines of insurance.

Policyholder Services

The administration of group policies and marketing issues have been outlined above. The billing procedures and notices are prompt, and the Company appears to be processing Change of Beneficiary forms within a day or two of receiving them. Premium refunds were issued according to statute. The Company was giving its insureds proper and timely notice of cancellation and rescission. The computer system lists all state interest rates in which policies are issued and pays interest on death benefits according to each state's laws.

The Company reserves the right to declare dividends and does not make promises that it will pay dividends. Individual policyholders receive year-end interest rates for the past year at time of renewal in annual letters.

The Company does not have any policies in place for remitting unclaimed property to the state under N.D. Cent. Code § 47-30.1-01, et seq. So far the Company feels that it has been able to find all beneficiaries.

One practice of concern is communications to individual policyholders for denials. In Group # 8188000, a memo was found from the Company to the agent advising that an insured was not eligible for a waiver of premium. The memo said, "Please advise us if the employer would like a formal denial letter." The Department would recommend such communications be addressed directly to the insured individual, not the employer or agent.

Underwriting

Policy Forms and Filings

All of the forms used were reviewed for conformity with North Dakota statutes, regulations, and bulletins. Dozens of forms have been submitted to the Department and approved. It was difficult to track the contracts, guides, procedures manuals, and their corresponding forms because the Company uses two different sets of numbering systems--one of their own, starting with letters, and an internal numerical tracking system designation that D&H uses on its own forms. The recent form submissions all use the alphabetical designations, but the older life and disability submissions sometimes still have the numerical designations. Some marketing guides, procedures manuals, and older contracts refer to both sets of numbers. As an example, the examiner had trouble matching Form PDP-LTD-85-5.0 with an application, but assumed the proper document was numbered # 29301060.

> *Recommendation No. 10: The Company should synchronize its numbering system for submissions to the Department and use this throughout all of its publications. This will minimize internal and external confusion, possible agent error, and the chance that groups could be provided forms and guides that do not match with the specific contracts.*

The Company appeared for the most part to be using forms approved by the Department but due to the numbering system, it was a bit unclear if the correct forms were used for each plan offered. One form, EE-4L-6.2.1, was specifically disapproved by the Department in November 1999, for long-term disability policies, as misapplying the pre-existing condition limitations specified in N.D. Cent. Code § 26.1-36-05(5). This form is also referred to as the "12/24 pre-x" by the Company.

The examiner's review of policy forms detected an identical form, EE-4LV-6.1.1, on Plan A or Plan B of long-term disability contracts that similarly misapplies N.D. Cent. Code § 26.1-36-05(5) provisions of pre-existing coverage. This form was also to have been withdrawn by the Company pursuant to a letter from the company to the Department one month before the commencement of the examination. The production of the form during the exam was an indication that it had not been withdrawn and was still in use.

> *Recommendation No. 11: The Company should withdraw use of Form EE-4LV-6.1.1 because it violates the provisions of N.D. Cent. Code § 26.1-36-05(5) and replace it with a form that complies with the statute.*

Group applications for voluntary benefits also misapply the pre-existing condition limitation period in listing the plan features of the long-term disability coverage. Specifically, VGTLA-19500, also identified as #29301265(6071)3-95, lists pre-existing coverage as "12/24." All forms approved by the Department applicable to group coverage of pre-existing conditions should list coverage limitations as "12/12/24" to reflect the 12-month look back period, the 12-month look forward period, and the 24 months of total application.

Recommendation No. 12: The Company should withdraw Form VGTLA-19500 because it violates N.D. Cent. Code § 26.1-36-05(5) and replace it with a form that complies with the statutory language.

Amendatory Riders

The Company has been using unapproved amendatory riders in violation of the following statutes: N.D. Cent. Code §§ 26.1-30-30, 26.1-30-19, and 26.1-33-31 which mandate prior approval by the Department of all forms and riders used. A random check of files found dozens of the riders attached to master policies only, and customized to define, add or delete benefits, indicate rate changes, place conditions on coverage, or simply indicate housekeeping matters. Many changes occurred during the middle of a policy period and not on an anniversary date.

There was no indication that the additional rider provisions agreed to by the employer and the insurer were being communicated to the individual certificate holders and, if not, these practices violate several statutes: N.D. Cent. Code § 26.1-33-11(8), indicating that the certificate of coverage sets forth coverage the individual is entitled to; § 26.1-29-16, mandating disclosure; and § 26.1-29-17, concerning materiality of disclosures. The Company was apparently not issuing amended or revised schedules of benefits after using a rider to change or amend the contract.

Recommendation No. 13: The Company should bring its practices with respect to the amendatory riders into compliance with N.D. Cent. Code §§ 26.1-29-16, 26.1-29-17, and 26.1-33-11(8) .

The Company was also advised that if contracts or certificates are for one or two years' duration, changes should come only on renewal/anniversary dates, unless the Company has specifically reserved the right to make such changes. Only one of the contracts reviewed contained any mention of the right to change coverage provisions.

Underwriting Procedures and Manuals

The regional service offices have computer software for agents to underwrite group life and short-term disability coverage. Long-term disability (LTD) coverage is underwritten by Lincoln at its home offices using D&H software for the small groups.

The life insurance underwriting manual currently in use is well-conceived, well-written, and understandable. It is undated but relatively new; a comprehensive plan, in which short-term disability, accidental death and dismemberment, and dependent coverage all have guidelines. The short-term disability guidelines are aggressively designed to help ailing employees while discouraging malingering. The Company should regularly monitor the service centers to ensure that agents are using the manuals and understand their contents.

One of the older life/disability underwriting manuals recommended against selling coverage to religious organizations and should be retired. The presumed rationale would be that because coverage is based on salaries and religious organizations sometimes have volunteers or nearly indigent employees, that such organizations present a poor risk or coverage cannot be precisely

determined. This may be an overly broad stereotype and the Company should be discouraged from using any potentially discriminatory materials.

The Company appeared to be approving applications and issuing policies promptly, informing individuals quickly of adverse underwriting decisions, and properly rejecting coverage.

Under the "General Administration" section of the manual, there are guidelines to administering the group plans. The Administration Kit, the installation instructions read, "is intended to show the policyholder that LMLC is responsible and intends to administer this contract in an efficient manner." The materials further stress the importance of correctly filling out applications and forms.

Claims Handling

Pioneer Mutual handled LML's claims from 1991 until January 1, 1999. A decision was made at that time to bring the claims department in-house. It was a sound decision. The Company's one-person claims department is an example for other companies to emulate. The sole employee is efficient, compassionate, and accurate. She issues claims checks the day she gets approval or the necessary forms and is astute about monitoring outstanding claims.

However, the Company does not have claims handling manuals for any of its lines of business and does not have written procedures in place for handling claims. The Prohibited Practices Act, N.D. Cent. Code § 26.1-04-03(9)(b) and (c), mandates that companies adopt reasonable standards for claims handling.

Recommendation No. 14: The Company should adopt written procedures for claims handling to ensure compliance with N.D. Cent. Code § 26.1-04-03(9) (b) and (c).

Life Claims

A random sampling of group life claims found that, with the exception of one claim, all death benefits were paid within the statutory 60-day limit. The Company's computerized payment system appeared to be correctly applying the various states' (of insured's death) interest rates, which were paid. The Company promptly investigated any claims that looked suspect and quickly issued denials or paid claims.

It is recommended that when the Company denies a claim, it attach the pertinent portion of the policy to the denial letter as support. That way claimants can read for themselves the policy language justifying the denial.

Claim No. 99LLIF027 violates N.D. Cent. Code § 26.1-33-05(9), which mandates payment of death benefits within 60 days of proof of loss. The insured person died on December 15, 1998. Proof of loss was filed on January 29, 1999. Reinsurance forms were sent to Medical Life Insurance Company on February 2, 1999. The same forms were re-faxed to Medical Life on April 16, 1999. It is unclear why there was a delay and need to re-send the paperwork. The claim was paid on April 19, 1999.

In death benefit claims, employers file the claim form, titled “Statement of DeathY Employer’s Form.’ Question No. 11 asks, “Do you recommend payment of this claim?” This could potentially put the employer at risk of a lawsuit if the “no” box should be checked and should be reconsidered.

Claim No. 99LLIF247 illustrates the problems that sympathetic employers can pose to insurers. A longtime employee became disabled, but the employer kept him on the payroll and told the Company he was working out of his home. There were no payroll hours to support the salary. Meanwhile the employer switched insurers while the employee was disabled. The employee eventually died. It took the two insurers some extensive dealings to sort out responsibility for the claim, which Lincoln paid. It was apparent that the employer was trying to keep the man in an eligible position to receive benefits, but it thwarted the insurers’ attempts to determine coverage. The decision would have been made easier if the employee had simply taken the disability leave that he was entitled to. The employer seemed under the mistaken impression that benefits were easier to obtain with actively employed status and may represent another example of compliance problems with N.D. Cent. Code § 26.1-33-02.

In another case, Group No. 8188000, the employer wrote the agent to say he was deliberately keeping a disabled employee on the payroll to keep the life insurance policy active. This case actually involved a waiver of premium denial in a disability claim. The Company wrote the agent to explain the denial, indicating “please advise us if the employer would like a formal denial letter.” Again, all denials of benefits should be directed to the employee directly and copied to the employer if there are no privacy concerns.

Claim No. 98LLIF099 appeared to have been misdated because the date of the claim was listed two weeks before the insured person died.

As with many of the files, there were no applications or policy provisions in the hard copy claims files. This sometimes made it more difficult for the Company to determine eligibility and could lead to claims delays. Until the computer system controls can be made reliable, it is recommended that the Company put copies of applications in all claims files along with pertinent contract language supporting or denying each claim.

Accidental death and dismemberment claims are handled along with life insurance claims on one form. The form indicates that if death was accidental or criminal, a coroner’s report and/or copy of the police report should be furnished. Initial letters to beneficiaries should reinforce this point because many claimants submitted death certificates but not the required coroner’s reports. This led to claim delays, and the Company writing a second time to beneficiaries requesting the reports.

The Company is properly applying N.D. Cent. Code § 26.1-36-04(2)(h) in investigating AD&D claims caused by intoxication. In all cases, the Company correctly denied coverage of accidental death claims when death was directly caused by intoxication and based all denials on coroner’s reports or autopsy results.

No problems were noted in the individual life claims. In two cases, beneficiaries or estates had to write the Company requesting IRS Form 712 for estate tax purposes. The Company should either send these in an initial letter to beneficiaries or offer to provide them rather than wait for executors to request the forms.

The claims officer has set up a “tickler” system to make note of claims forms submissions sent out. That way she can better track delinquent submissions and speed up payments. She did this promptly after assuming her new position when she noticed that Claim No. 98LLIF079 submissions forms had been sent out on April 9, 1998, with no response. She sent out the reminder on January 8, 1999. The claim was paid February 23, 1999. Now reminders are sent out in 30 to 60 days if the submissions have not arrived.

Disability Claims

When employers cooperated and were efficient in assisting the employee to get the claim filed, the process worked well. Disabled persons received checks on a weekly basis, usually three days before the end of the disability period. The claims manager made sure that checks mailed out over the Christmas and New Year’s holidays arrived on time and factored in mail delays.

One file, Claim No. 99LSTD067, did not reflect whether payment had been made to the disabled employee.

The handling of maternity claims raises concern. The Company was automatically terminating benefits after six weeks, despite the fact that a physician may have disabled the employee longer. In at least two cases found, the women were disabled due to c-section deliveries. If these were nonelective, N.D. Cent. Code § 26.1-36-09.2 applies. The contract does not specify that only six weeks of maternity leave are covered. Additionally, N.D. Cent. Code § 26.1-36-09.2 specifies that involuntary complications of pregnancy must be covered the same as other benefits under a health service contract.

The Company asserts that no complications of pregnancy arose so it was in compliance with all statutes. But its files did not contain evidence that it ascertained whether any complications were present, so compliance on its part was based on the assumption that all the disabled women claimants were able to return to work six weeks after giving birth. For example, Claim No. 96LSTD130 involved a C-section delivery in which the claimant was disabled for six weeks. The Company paid five weeks of benefits. It is unknown based on the file, whether the woman experienced any complications of pregnancy or if the C-section was elective.

Claim No. 96LSTD004 involved another pregnancy. The woman was paid five weeks of benefits, then was called by the Company and told if she wanted additional benefits she needed to get her physician to fill out another APS. The short-term disability contracts specify that claimants are eligible if they are being regularly treated by a physician. The Company appears to be using case-by-case standard as to what constitutes regular treatment and whether additional proof as to continuing treatment is to be furnished with claims. The above-mentioned claimant was told to furnish additional proof at a five-week period. Other claimants must furnish proof monthly or periodically. This again is reason to invoke the provisions of N.D. Cent. Code § 26.1-04-03(9)(c), which mandates that a Company adopt reasonable standards for handling claims.

The exam revealed several letters limiting maternity benefits to an automatic six-week period regardless of how long the physician was disabling the woman after giving birth. In another case, the Company told a female employee that it only allowed six weeks of leave following a hysterectomy, when the contract contained no such limitations. These claims were specifically brought to the Company’s attention during the exam, and the Company indicates these form letters have been changed.

N.D. Admin. Code § 45-03-10-04(6) mirrors N.D. Cent. Code § 26.1-36-09.2 and prohibits insurers from treating complications of pregnancy differently from any other illness or sickness under a contract. Section 7 of the same rule prohibits "restricting, reducing, modifying or excluding benefits relating to coverage involving genital organs of only one sex."

Because the Company was applying this limitation of benefits to maternity cases but otherwise accepting a doctor's determination of disability in other cases, the Company has established different conditions under which the policyholder may exercise benefit options in the contract. This is prohibited by N.D. Admin. Code § 45-03-10-04.

> *Recommendation No. 15: The Company should bring all of its disability claims handling practices into compliance with all applicable statutes, including N.D. Cent. Code § 26.1-36-09.2 and N.D. Admin. Code § 45-03-10-04.*

The long-term disability claims had no major discrepancies. The Company, with the exception of two claims, was promptly acknowledging claims, issuing regular payments, coordinating benefits with Social Security Disability Insurance, and monitoring ongoing claims. Claim No. 98LLTD003 did not contain an acknowledgment of the claim or explanation of benefits letter. The Company should make sure that all individual claimants get an acknowledgment that a claim has been filed and that a copy of the acknowledgment goes to the employer.

As a housekeeping matter, the Company should revise its computer program to allow input for deductions to be designated on the actual disability checks. The Company does not send out monthly explanations of benefits, but simply mails out the check. The checks do not reflect the benefit amounts deducted for Social Security or FICA so that the employee cannot verify the deductions and keep personal records. The checks should contain a gross amount with deductions paid and those totals should reconcile with the net amount of the check.

Contested Claims

During the examination period, 12 contested claims were listed on Schedule F of the Company's annual reports from 1994-1998. Nine of the claims were provided to examiners. Three claims, 96LIF023, 95LL063, and 95LL027, were not provided. The examiner was told they could not be located.

> *Recommendation No. 16: The Company should develop a better system of file maintenance and retrieval so that it does not lose files.*

Claim No. 98LADD003 was an accidental death claim that was properly denied, but the Company sent an e-mail to the group as a denial. No letter went to the insured person's beneficiaries. Again, denials should be sent directly to those insured persons, and the employer can be copied the response if it does not compromise the insured's privacy.

Claim No. 97LLIF135 was a denial of death benefits, again due to the retirement of the insured individual. The contract certificate and letter of benefits explanation appear to contain no language of conversion as required by N.D. Cent. Code § 26.1-33-12. Unless the Company can furnish written proof that the deceased was informed of his conversion rights, the claim should be paid with interest.

Recommendation No. 17: The Company should furnish the Department proof that the deceased was provided written notice of his option to convert his group policy to an individual one, in accordance with N.D. Cent. Code § 26.1-33-12, or pay Claim No. 97LLIF135 with interest to the beneficiaries.

Claim No. 96LLIF046 was another denial of death benefits to a retired individual. The application is of such poor quality as to be unreadable. The policy schedule listed a $1,000 death benefit after age 70. The Company used an unapproved amendatory rider to terminate the benefits at retirement. The claim file does not reflect that a new schedule of benefits was sent to the insured person, so this rider may not have put the deceased on notice that her benefits had been restricted in a material way. The contract also does not appear to provide language of conversion as discussed above.

Recommendation No. 18: The Company should furnish the Department proof that the deceased was provided written notice of changes of coverage contained on the amendatory rider and the policy gave notice of her option to convert her group policy to an individual one, or pay the Claim No. 96LLIF046 with interest to the beneficiaries.

Health Claims

In some cases it was impossible to determine if dental claims were being paid in a timely manner because receipt dates had been stamped on the submissions and were difficult to read, and the forms themselves were electronically submitted by the provider.

One claim needs investigation and possible further payment. Claim No. 98007176-01 was a mental health claim that was denied. It was unclear if the diagnosis code was correct.

Recommendation No. 19: Lincoln Mutual should have BPA order the chart notes from Claim No. 98007176 to determine if the services are to be paid and report any findings to the Department. If the claim was incorrectly coded and benefits are owed, Lincoln should consider paying the claim.

SUMMARY OF RECOMMENDATIONS

1. Lincoln Mutual should ensure compliance with all licensing and statutory requirements by any entity with which it contracts.

~~2.~~ The Company needs to bring its practices in soliciting life insurance and administering the policies into compliance with N.D. Cent. Code § 26.1-33-02.

3. A completed application should be attached to the various policies in accordance with N.D. Cent. Code §§ 26.1-33-05(4) and 26.1-33-11(3), as it forms an integral part of the contract. Under N.D. Cent. Code § 26.1-33-01 the complete form should be provided to

both policyholder or and certificate holder and a copy of both the application and the contract should be retained by the company.

~~4.~~ The Company must exercise due diligence to ensure compliance with N.D. Cent. Code §§ 26.1-02-24.1 and 26.1-02.1-02.

5. The Company should adopt and follow formal procedures for complaint handling, including the use of a complaint register, and maintain thorough records on a calendar year basis as set forth in N.D. Cent. Code § 26.1-04-03(10). Additionally, the Company should develop grievance procedures as set forth in N.D. Cent. Code § 26.1-36-42 and include these procedures in all life and disability contracts.

6. The Company should bring its notice of conversion practices into compliance with N.D. Cent. Code §§ 26.1-33-11(9) and 26.1-33-12 and provide written notice or require proof of written notice to all terminated, retired, or otherwise ineligible employees or dependents of their rights to convert any group policies to individual coverage. If conversion options do not exist on certificates, individuals should receive written notification under the statutes.

7. The brochures and promotional materials delivered to potential policyholders should contain definitions of all key terms so that prospective insureds can make informed decisions about whether to purchase coverage and to fully advise them of the benefits they are purchasing. Those definitions should match the definitions in the materials employers will use to explain or administer the plans.

8. The Company should review all contracts, brochures, and manuals in force and bring descriptions of key terms into compliance with existing North Dakota laws.

9. Lincoln should review all of its agent files to ensure that agents are properly licensed and appointed to sell the various lines of insurance.

10. The Company should synchronize its numbering system for submissions to the Department and use this throughout all of its publications. This will minimize internal and external confusion, possible agent error, and the chance that groups could be provided forms and guides that do not match with the specific contracts. All older contract forms, guides, benefits schedules, and promotional literature should be renumbered to follow the same overall plan of identification.

11. The Company should withdraw use of Form EE-4LV-6.1.1 because it violates the provisions of N.D. Cent. Code § 26.1-36-05(5) and replace it with a form that complies with the statute.

12. The Company should withdraw Form VGTLA-19500 because it violates N.D. Cent. Code § 26.1-36-05(5) and replace it with a form that complies with the statutory language.

13. The Company should bring its practices with respect to the amendatory riders into compliance with N.D. Cent. Code §§ 26.1-29-16, 26.1-29-17, and 26.1-33-11(8).

14. The Company should adopt written procedures for claims handling to ensure compliance with N.D. Cent. Code § 26.1-04-03(9)(b) and (c).

15. The Company should bring all of its disability claims handling practices into compliance with all applicable statutes, including N.D. Cent. Code §§ 26.1-04-03(9)(c) and 26.1-36-09.2 and N.D. Admin. Code Chapter 45-03-10 et seq.

16. The Company should develop a better system of file maintenance and retrieval so that it does not lose files.

17. The Company should furnish the Department proof that the deceased was provided written notice of his option to convert his group policy to an individual one in accordance with N.D. Cent. Code § 26.1-33-12 or pay Claim No. 97LLIF135 with interest to the beneficiaries.

18. The Company should furnish the Department proof that the deceased was provided written notice of changes of coverage contained on the amendatory rider and the policy gave notice of her option to convert her group policy to an individual one or pay Claim No. 96LLIF046 with interest to the beneficiaries.

19. Lincoln Mutual should have BPA order the chart notes from Claim No. 98007176 to determine if the services are to be paid and report any findings to the Department. If the claim was incorrectly coded and benefits are owed, Lincoln should consider paying the claim.

CONCLUSION

An examination has been conducted of the market conduct affairs of Lincoln Mutual Life Insurance Company for the period of July 1, 1994, through December 31, 1999.

The exam was conducted in accordance with NAIC procedures. Sarah Smith, Market Conduct Examiner, performed this exam.

EXAMINATION REPORT SUBMISSION

The Company's cooperation in this exam is hereby noted. This examination report is respectfully submitted to the Honorable Jim Poolman, Commissioner of Insurance, North Dakota Insurance Department.

Respectfully submitted,

_____

Douglas L. Holloway
Deputy Commissioner
N.D. Insurance Department

CONFIDENTIAL

STATE OF NORTH DAKOTA

BISMARCK, NORTH DAKOTA

REPORT OF EXAMINATION

OF

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA

FARGO, NORTH DAKOTA

AS OF DECEMBER 31, 1995

Action/Response by Company: BCBSND made adequate disclosure of its deferred compensation and retirement plans in its December 31, 1995, Annual Statement.

RECOMMENDATION NO. 5

It is recommended that BCBSND continue to report all line item administrative expenses on Part 3 of the Annual Statement blank at net on all subsequent Annual Statements.

Action/Response by Company: BCBSND reported all line item administrative expenses on Part 3 of the December 31, 1994 and 1995, Annual Statements at amounts net of expenses related to subsidiaries and affiliates.

RECOMMENDATION NO. 6

It is recommended that BCBSND prepare an annual report analyzing the impact of the agreements with LM and PM on each entity and that such analysis be presented to the Board of Directors and this Department for review.

Action/Response by Company: BCBSND prepared a two-page narrative describing 17 operational areas that have been merged because of the joint venture agreements with Lincoln Mutual Life Insurance Company (LML) and Pioneer Mutual Life Insurance Company (PML). The narrative gives examples of savings and increased efficiencies gained through the combined operations, but does not provide actual data supporting the examples. The narrative was reviewed by the Boards of BCBSND, LML, and PML.

RECOMMENDATION NO. 7

It is recommended that BCBSND exclude ASO business and all other uninsured business from the Underwriting and Investment Exhibit.

Action/Response by Company: BCBSND excluded ASC/ASO business from premiums and claims reported on the Underwriting and Investment Exhibit of the December 31, 1995, Annual Statement. The Company's method of reporting in the December 31, 1994, Annual Statement was consistent with prior periods.

RECOMMENDATION NO. 8

It is recommended that BCBSND develop a system to separate consumer complaints from other consumer inquiries in order that the frequency and nature of complaints can be tracked.

Action/Response by Company: A system to separate customer complaints from other consumer inquiries was developed in May 1996. BCBSND defines a complaint as a written communication expressing a grievance about an injury (financial), injustice, or wrong which gives grounds for complaint because it is perceived by the customer as unjust, discriminatory, and oppressive.

APPENDIX "C"

DISABILITY GROUPS SAMPLED

8154700	2220800	2245500	2259700
2279900	8169000	8079700	2231300
2235500	2203300	8133700	2210400
2216600	2218100	2226100	8135800
8144600	8150300	8158300	8165400
8178900	8014400	8041800	8060000
8097600	8105400	8121100	8124100
8135600	8036600	8049201	8049204
8049208	8090700	8102700	8115500
8123500	8129800	8140700	8148800
8156600	8161300	8166100	8184900

LIFE GROUPS SAMPLED

2001900	2202700	2202900	2205613
2206100	2209000	2210400	2212400
2215100	2217800	2219100	2222700
2226500	2226900	2230300	2231500
2233600	2234600	2239600	2240703
2246000	2253600	2270400	7505400
7508900	7728100	8013200	8016400
8025600	8027100	8035100	8043200
8052800	8064701	8072200	8077000
8090700	8100000	8115000	8137700
8145001	8146900	8160100	8169000
8179600	8183300	8184200	2216600

INDIVIDUAL LIFE POLICIES SAMPLED

125252	125711	126761	126919
127321	127927	128492	129150
129448	130114	131253	131786
132819	133677	135547	136100
137742	139878	141487	142470
143408	150264	152962	154526
156387	158412	167947	170494
172033	186230	186658	187215
187724	188511	189374	189781
190472	191007	191514	191866
192571	193363	194706	195282
195474	5279195		

LIFE CLAIMS REVIEWED (individual and group)

97LLIF273	98LLIF041	98LLIF065	98LLIF099
98LLIF174	98LLIF195	98LLIF210	98LLIF247
99LLIF027	99LLIF040	99LLIF088	99LLIF099
99LLIF128	99LLIF137	99LLIF191	99LLIF245
99LLIF272	96LLIF057	97LLIF223	97LLIF272
98LLIF004	98LLIF008	98LLIF036	98LLIF044
98LLIF054	98LLIF067	98LLIF079	98LLIF087
98LLIF142	98LLIF169	98LLIF177	98LLIF18
98LLIF204	98LLIF232	98LLIF239	98LLIF253
98LLIF260	99LLIF003	99LLIF015	99LLIF030
99LLIF039	99LLIF051	99LLIF060	99LLIF067
99LLIF084	99LLIF102	99LLIF121	99LLIF123
99LLIF133	99LLIF151	99LLIF157	99LLIF158
99LLIF163	99LLIF184	99LLIF204	99LLIF211
99LLIF217	99LLIF233	99LLIF253	99LLIF264

DISABILITY CLAIMS REVIEWED

97LSTD079	97LSTD063	97LSTD053	97LSTD019
97LSTD004	96LSTD134	96LSTD165	96LSTD145
96LSTD130	96LSTD104	96LS088	96LS076
96LS084	96LS053	96LS035	96LS010
97LSTD132	97LSTD091	96LL014	98LSTD155
98LSTD193	99LSTD008	99LSTD022	99LSTD033
99LSTD049	99LSTD056	99LSTD067	99LSTD076
99LSTD089	99LSTD098	99LSTD110	99LSTD117
99LSTD124	99LSTD138	99LSTD152	99LSTD157
99LSTD162	99LSTD177	99LSTD191	96LSTD134
97LSTD004	97LSTD019	97LSTD031	97LSTD053
97LSTD063	97LSTD079	97LSTD091	97LSTD115
97LSTD128	97LSTD132	97LSTD143	97LSTD165
97LSTD167	95LSTD118	95LSTD141	96LSTD010
96LSTD035	96LSTD053	96LSTD076	96LSTD084
96LSTD088	96LSTD104	96LSTD130	96LSTD138
96LSTD145	96LSTD165	94NSTD165	94NSTD184
94NSTD188	95LSTD007	95LSTD017	95LSTD022
95LSTD037	95LSTD040	95LSTD066	95LSTD074
95LSTD106	95LSTD117	95LSTD120	95LSTD138
95NSTD014	95NSTD029	95LLTD010	96LLTD005
96LLTD014	98LLTD003	99LLTD002	